Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R		
		N039003	B. WING		08/19/2014		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
ATTICA LONG TERM CARE FACILITY  ATTICA, KS 67009							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION	J (X5)		
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE		
{S 000}	INITIAL COMMENTS		{S 000}				
{S 600} SS=C	28-39-158(a) DIETARY SERVICES		{S 600}				
	Dietary services. The provide each resident	e nursing facility shall with nourishing, palatable,					
	attractive, non-contan	ninated foods that meet the pecial dietary needs of each					
	resident. A facility that	at has a contract with an					
	_	d management company shall be in compliance with this regulation if					
		ne requirements of these					
	(a) Staffing.						
	(1) Overall supervisory responsibility for the dietetic services shall be the assigned responsibility of a full-time employee who is a licensed dietitian or a dietetic services supervisor who receives regularly scheduled onsite						
	supervision from a lice	ensed dietitian. The nursing					
	assure adequate time supervision.	ufficient support staff to for planning and					
		ty shall implement written es for all functions of the					
	dietetic services depa	rtment. The policies and					
	procedures shall be a department.	valiable for use in the					
		rvices supervisor shall meet stated in K.A.R. 28-39-144(r)					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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Nansas L	bepartment on Aging						
`` '		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
					_		
			B. WING		F		
		N039003	B. WING		08/1	9/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE ZIP CODE			
				,			
ATTICA L	ONG TERM CARE FACIL	ITY 302 N BC					
		ATTICA,	KS 67009				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETE DATE	
TAG			TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MAIL	DAIL	
				,			
{S 600}	Continued From page	e 1	{S 600}				
, ,			` '				
	This REQUIREMENT	Γ is not met as evidenced					
	by:						
	KAR 28-39-158(a)(1)	1					
		isus of 51 residents. All 51					
	_	epared in the main kitchen.					
		n, interviews, and record					
		enrollment schedule, the					
	facility failed to assign						
		etic services to a full time					
		censed dietician or a dietetic					
		Certified Dietary Manger)					
	who receives regular	, ,					
	_	-					
	supervision from a lic	ensed dietitian.					
	Finding included:						
	-Review of the billing from Dietary Consultant E						
		d the facility for 10 ½ hours					
		19 hours the week of July					
		ek of July 14th, 17 hours the					
	week of July 21st, an	d 23 hours the week of July					
	28th.						
	Review of Student Se	ervices account for Dietary					
	Staff D from the curre	ent enrollment receipts dated					
	8/5/14 revealed dieta	ry staff D to be enrolled in					
	Human Resource Ma						
		n Resources Management					
		The fall of 2014 dietary staff					
		nitation and Management of					
		with Field Experience					
	_	gement of Food Systems.					
	_	working towards his/her					
	Certified Dietary Man	lager Certificate.					
		e week of 8/4/14 through					
	8/7/14 revealed Dieta	ary Consultant E was in the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BOILDING			R		
		N039003	B. WING		08	/19/2014		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	ΓΕ, ZIP CODE	-			
302 N ROTKIN								
ATTICAL	ONG TERM CARE FACIL	ATTICA,	KS 67009					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE		
{S 600}	ONG TERM CARE FACILITY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		{S 600}	DEFICIENCY)				